CHAPTER 62

VISION CARE MANUAL

Division of Medical Assistance and Health Services
VISION CARE SERVICES
N.J.A.C. 10:62
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TABLE OF CONTENTS

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

SUBCHAPTER 1. EYECARE: PROFESSIONAL SERVICES

10:62-1.1 Scope

This subchapter delineates the New Jersey Medicaid and NJ FamilyCare fee-for-service program standards for examinations and care for vision defects and/or eye diseases for the purpose of maintaining or improving the health of New Jersey Medicaid and NJ FamilyCare fee-for-service beneficiaries.

10:62-1.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise:

"Ophthalmologist" means a fully licensed medical doctor who has been recognized by the New Jersey Medicaid or NJ FamilyCare fee-for-service program as a specialist in ophthalmology.

"Optometrist" means any person who is licensed by the New Jersey State Board of Optometry to engage in the practice of optometry, or licensed to engage in the practice of optometry in the state in which he or she performs such functions.

"Practitioner" means a licensed ophthalmologist or optometrist, acting within the scope of licensure.

"Transfer" means the relinquishing of responsibility for the continuing care of the beneficiary by one practitioner and the assumption of such responsibility by another practitioner.

10:62-1.3 Providers of professional services

(a) Within the restrictions of their respective licensure, the following are eligible providers of eye care upon fulfilling the Enrollment Process requirements in N.J.A.C. 10:49-3.2:

1. Ophthalmologists or optometrists licensed in the State of New Jersey;
2. Ophthalmologists or optometrists in another state who are duly licensed in that state;
3. Independent clinics approved by the New Jersey Medicaid or NJ FamilyCare fee-for-service program to render eye care services; and
4. Hospitals meeting the definition of "approved hospital" as described in N.J.A.C. 10:52-1.1 of the Hospital Services Manual.

10:62-1.4 Covered services

Professional services include office visits for evaluation and management, comprehensive eye examinations, low vision examinations, low vision work-ups, vision training work-ups, vision training program visits as well as other specific procedures as listed at N.J.A.C. 10:62-3.2. Payment is made subject to the limitations specified under each type of service. If a service

requires prior authorization, see N.J.A.C. 10:62-1.16.

10:62-1.5 Comprehensive eye examination

(a) A comprehensive eye examination may include cycloplegics and a post cycloplegic visit. All findings and data, including positive and negative, shall be clearly recorded. A comprehensive eye examination shall include the following, as a minimum, where possible unless contraindicated:

1. Detailed case history;
2. Complete visual acuity findings;
3. External and internal (ophthalmoscopic) examination including slit lamp;
4. Refraction (objective and subjective);
5. Extra-ocular measurement (EOM);
6. Gross visual fields (central and peripheral);
7. Tonometry (when indicated for patients under 35; mandatory for all patients over 35). The specific method used should be identified and recorded (the finger palpation test is not acceptable);
8. Binocular coordination testing (distance and near), fusion, steropsis, and color vision;
9. The diagnosis (ocular deficiency or deformity, visual or muscular anomaly, and so forth); and
10. Recommendations.

(b) For reimbursement purposes, a comprehensive eye examination shall include all the criteria of a comprehensive eye examination plus complete Diagnostic Visual Fields.

1. Comprehensive eye examinations with diagnostic fields are not routinely reimbursable for complete comprehensive eye examination. Patients should be selected for this additional service based upon history and ophthalmologic findings during the examination if the physical examination suggests the presence of optic or motor nerve abnormalities, or if other significant physical findings are present and documented, diagnostic visual field studies may be selectively employed to establish or to confirm the diagnosis and/or the degree of impairment.
2. A comprehensive eye examination with or without diagnostic fields shall be limited to once a year.

10:62-1.6 Low vision examination

(a) General policies regarding the collection of personal contribution to care for NJ FamilyCare-Plan C service are set forth at N.J.A.C. 10:49-9.

(b) Personal contribution to care for NJ FamilyCare-Plan C services is $5.00 a visit for office visits, except when the service is provided for preventive care.

1. An office visit is defined as a face-to-face contact with a vision care professional, which meets the documentation requirements in this subchapter and N.J.A.C. 10:62-4.
2. Office visits include eye care professional services provided in the office, patient's home, or any other site, excluding hospital, where the child may have been examined by the vision care

professional. Generally, these procedure codes are set forth in N.J.A.C. 10:62-3.2 and 3.3.

(c) Vision care professionals shall not charge a personal contribution to care provided to newborns, who are covered under fee-for-service for Plan C; or for preventive services.

10:62-1.7 Low vision work-up

A low vision work-up as defined in N.J.A.C. 10:62-3.3 requires prior authorization (see N.J.A.C. 10:62-1.16). For purposes of the New Jersey Medicaid and NJ FamilyCare fee-for-service programs, a low vision work-up consists of certain testing techniques and procedures to determine what optical aids and devices can be prescribed for an individual to increase range of vision. A low vision work-up requires a written report and is much more detailed than the low vision examination that follows a complete comprehensive examination.

10:62-1.8 Vision training program

(a) Vision training requires prior authorization (see N.J.A.C. 10:62-1.16). For purposes of the New Jersey Medicaid and NJ FamilyCare fee-for-service programs, vision training is the use of certain procedures and modalities for the development of and/or increase in the vision capacity of the eye(s) with poor and/or inconsistent or distorted vision localization.

(b) Vision training is limited to orthoptics, with its acceptable procedures and/or modalities, and further limited to the following types of conditions to be treated by private physicians approved for such training by the respective peer group:

1. Strabismus;
2. Amblyopia;
3. Heterophoria; and
4. Accommodative and/or convergence anomalies.

(c) If vision training is required following the initial comprehensive eye examination, the practitioner shall submit a written request (form FD-358) to the Vision Care Unit for prior authorization (see N.J.A.C. 10:62-1.16) for a vision training work-up. This request shall include the preliminary findings, detailed reason(s) why it is believed a further evaluation is needed, and any history of previous vision training with the dates and the results. Upon receiving approval for a vision training work-up, the practitioner shall then submit, within 30 days of receipt of authorization, the work-up report to the Vision Care Unit. The vision training work-up report shall consist of, but not be limited to:

1. Diagnosis;
2. Findings;
3. Interpretation;
4. Recommendations;
5. Outline of training procedures and frequency of sessions with estimated duration of treatment; and
6. Prognosis.

(d) The decision of the Vision Care Unit to approve or deny vision training will be transmitted to the practitioner by the fiscal agent.

(e) Upon completion of an approved training program, the practitioner shall submit a detailed progress report, listing the status of all parameters indicated in the original evaluation. No treatment plan shall exceed a period of 90 days or a total of 30 training visits, commencing with the inception of the treatment plan. An additional prior authorization is required for any extension of treatment and requires submission of a detailed progress report to the Vision Care Unit.

(f) Vision training may be provided by a practitioner when found medically necessary. This service can be performed in the office or in an independent clinic approved by the New Jersey Medicaid or NJ FamilyCare fee-for-service program.

10:62-1.9 New patient office visits

(a) HCPCS 99201, 99202, 99203, 99204, 99205, 99301, 99302, 99303, 99321, 99322 and 99323 are not reimbursable with 92002, 92004, 92012 or 92014 on the same day.

(b) When the setting for the initial visit is an office or residential health care facility, for reimbursement purposes it is limited to a single visit. Future use of this category of codes shall be denied when the beneficiary is seen by the same physician, group of physicians, or shared health care facility. (See N.J.A.C. 10:49-4 for definition of shared health care facility.)

(c) Reimbursement for an initial office visit also precludes subsequent reimbursement for an initial residential health care facility visit and vice versa.

(d) When multiple special ophthalmological services or ophthalmoscopic services are billed on the same day for the same patient in an office setting, reimbursement shall be limited to the highest valued procedure.

10:62-1.10 Established patient office visits

(a) Codes 99201, 99202, 99203, 99204, 99205, 99301, 99302, 99303, 99321, 99322 and 99323 are not reimbursable with 92002, 92004, 92012 or 92014 on the same day.

(b) When multiple special ophthalmological services or ophthalmoscopic services are billed on the same day for the same patient in an office setting, reimbursement shall be limited to the highest valued procedure.

10:62-1.11 Emergency room visits

(a) When a physician sees the patient in the emergency room instead of the practitioner's office, the physician shall use the same HCPCS for the visit that would have been used if seen

in the physician's office (99211, 99212, 99213, 99214 or 99215 only). Records of that visit shall become part of the notes in the office chart.

(b) When patients are seen by hospital-based emergency room physicians who are eligible to bill the Medicaid or NJ FamilyCare fee-for-service program, then the appropriate HCPCS shall be used. The "Visit" codes are limited to 99281, 99282, 99283, 99284 and 99285.

10:62-1.12 Inpatient hospital services

(a) To qualify as documentation that the service was rendered by the practitioner during an inpatient stay, the beneficiary's medical record must contain the practitioner's notes indicating that the practitioner personally:

1. Reviewed the beneficiary's medical history with the beneficiary and/or his or her family, depending upon the medical situation;
2. Performed an eye examination, or other procedure;
3. Established, confirmed or revised the diagnosis; and
4. Visited and examined the beneficiary on the day(s) for which a claim for reimbursement is made.

(b) An initial hospital visit during a single admission shall be disallowed to the same physician, group, shared health care facility, or practitioners sharing a common record who submit a claim for a consultation and transfer the patient to their service.

(c) When performing corneal tissue transplant surgery, providers shall request and receive prior authorization for HCPCS V2785 (processing, preserving and transplanting corneal tissue). Ophthalmologists shall submit the completed "Request for Prior Authorization of Optical Appliances" to Division staff with the provider's laboratory invoice attached to the request.

1. Ophthalmologists shall not bill for V2785 when the procedure is performed in a hospital.

10:62-1.13 Consultations

(a) A consultation shall be recognized for reimbursement only when performed by a specialist recognized as such by the Medicaid or NJ FamilyCare program and the request has been made by or through the patient's attending physician and the need for such a request would be consistent with good medical practice. Two types of consultation shall be recognized for reimbursement: comprehensive consultation and limited consultation.

(b) In order to receive reimbursement for the HCPCS for an office consultation (99244, 99245) or a confirmatory consultation (99274 and 99275), the provider shall perform a total systems evaluation by history and physical examination, including a total systems review and total systems physical examination, or, alternatively, utilize one or more hours of the consulting physician's personal time in the performance of the consultation.

(c) In addition to the recordkeeping requirements of N.J.A.C. 10:62-1.20, reimbursement for

HCPCS 99244, 99245, 99274 and 99275 (Comprehensive consultation) requires the following applicable statements, or language essentially similar to those statements, to be inserted in the "remarks" section of the claim form. The claim form shall be signed by the provider who performed the consultation.

1. Examples:

i. I personally performed a total (all) systems evaluation by history and physical examination; or

ii. This consultation utilized 60 or more minutes of my personal time.

(d) The following regarding consultations shall also apply:

1. If a consultation is performed in an inpatient or outpatient setting and the patient is then transferred to the consultant's service during that course of illness, then the provider shall not bill for an Initial Visit if the practitioner billed for the consultation.

2. If there is no referring physician, then an Initial Visit HCPCS shall be used instead of a consultation HCPCS.

3. If the patient is seen for the same illness on repeated visits by the same consultant, such visits are considered routine visits or follow-up care visits, and not consultations.

4. Consultation HCPCSs shall be denied in an office or residential health care facility setting if the consultation has been requested by or between members of the same group, shared health care facility or physicians sharing common records. A Routine Visit code is applicable under these circumstances.

5. If a prior claim for a comprehensive consultation visit has been made with the preceding 12 months, then a repeat claim for this code shall be denied if made by the same physician, physician group, shared health care facility or physicians using a common record except in those instances where the consultation required the utilization of one hour or more of the physician's personal time. Otherwise, applicable codes would be Limited Consultation codes if their criteria are met.

(e) For reimbursement purposes, HCPCS 99241, 99242, 99243, 99251, 99252, 99253, 99271, 99272 and 99273 are considered "limited" because the consultation requires less than the requirements designated as "comprehensive" as noted in (c) above (Comprehensive consultation).

(f) When multiple special ophthalmological services or ophthalmoscopic services are billed on the same day for the same patient in an office setting, reimbursement shall be limited to the highest valued procedure.

10:62-1.14 Home services

(a) The House Call HCPCS 99343 and 99353 shall not apply to residential health care facility or nursing facility settings. These HCPCS refer to a physician visit limited to the provision of medical care to an individual who would be too ill to go to a physician's office and/or is "home bound" due to his or her physical condition. When billing for a second or subsequent patient

treated during the same visit, the visit shall be billed as a home visit.

(b) For purposes of Medicaid or NJ FamilyCare fee-for-service reimbursement, HCPCS 99341, 99342, 99351 and 99352 apply when the provider visits a Medicaid or NJ FamilyCare fee-for-service beneficiary in the home setting and the visit does not meet the criteria specified under Home Visit listed in (a) above.

(c) In addition to the recordkeeping requirements indicated in N.J.A.C. 10:62-1.18, the record and documentation of a home visit shall become part of the office progress notes and shall include, as appropriate, the following information:

1. The purpose of the visit;
2. The pertinent history obtained;
3. Pertinent physical findings, including pertinent negative physical findings based on (c)1 and 2 above;
4. The procedures, if any performed, with results;
5. Lab, X-ray ECG, etc., ordered with results; and
6. A diagnosis(es) plus treatment plan status relative to present or pre- existing illness(es) plus pertinent recommendations and actions.

10:62-1.15 Unusual travel and escort services

HCPCS 99082 may be used for travel costs only associated and billed with Home Visit. (See codes 99341, 99342 and 99343.)

10:62-1.16 Professional services requiring prior authorization

(a) Form FD-358 (Request for Prior Authorization for Vision Care Services) shall be used to request prior authorization for professional services. Instructions for completing the form are provided in the Fiscal Agent Billing Supplement. The completed form, clearly indicating the reasons for requesting the service requiring prior authorization, shall be submitted to the Vision Care Unit, Division of Medical Assistance and Health Services, Mail Code # 16, PO Box 712, Trenton, New Jersey 08625-0712. When a request for prior authorization is approved or denied, the provider shall receive a letter of notification from the fiscal agent.

(b) Items requiring prior authorization should not be provided to the Medicaid or NJ FamilyCare fee-for-service beneficiary until the authorization is received by the provider from the fiscal agent.

(c) The following professional services require prior authorization:

1. Low vision work-up;
2. Vision training program;
3. Vision training work-up; and
4. All other services not specified as a covered service under N.J.A.C. 10:62-1.4.

(d) Vision care provider services rendered to Medicaid or NJ FamilyCare fee-for-service beneficiaries who are enrolled in a health maintenance organization which includes these services in its benefits package must be prior authorized by the HMO/physician case manager. (See N.J.A.C. 10:49-21 for specifics on prepaid health plans and the Fiscal Agent Billing Supplement, for details for obtaining prior authorization.)

(e) Program reimbursement for intraocular lenses shall be limited to two implantation procedures per beneficiary per lifetime without prior authorization. Any request for an additional implantation procedure shall be prior authorized and shall include documentation regarding the medical necessity of the procedure.

10:62-1.17 Prescription policies

(a) Upon request, a beneficiary must be provided with his or her prescription for an optical appliance. The following information shall be indicated on the prescription: name, address, Medicaid or NJ FamilyCare fee-for-service Identification Number, date of examination, and diagnosis code(s).

(b) If a beneficiary requests a duplicate prescription, the duplicate prescription shall clearly indicate: "THIS IS A DUPLICATE." The date of the original prescription shall also be included. The dispensing provider shall retain the original prescription.

10:62-1.18 Prescribing medications

(a) All covered pharmaceutical services provided by licensed professionals of vision care services under the New Jersey Medicaid or NJ FamilyCare fee-for-service program shall be prescribed in accordance with the scope of their practice.

(b) The Pharmaceutical Services manual, N.J.A.C. 10:51, sets forth the provisions for covered and noncovered pharmaceutical services, prior authorization, quantity of medication, administration of drugs, pharmaceutical dosage and directions, telephone-rendered original prescriptions, changes or additions to the original prescription, non-proprietary or generic dispensing, and prescription refill.

10:62-1.19 Clinical laboratory services

(a) "Clinical laboratory services" means professional and technical laboratory services performed by a clinical laboratory certified by CMS in accordance with the Federal Clinical Laboratory Improvement Act (CLIA), 42 U.S.C. § 263a and ordered by a physician or other licensed practitioner, within the scope of his or her practice, as defined by the laws of the State of New Jersey and/or of the state in which the practitioner practices.

(b) Clinical laboratory services are furnished by clinical laboratories and by physician office laboratories (POLs) that meet the Centers for Medicare and Medicaid Services regulations pertaining to clinical laboratory services defined in the Clinical Laboratory Improvement

Amendments (CLIA) of 1988, section 1902(a)(9) of the Social Security Act, 42 U.S.C. § 1396(a)(9), and as indicated at N.J.A.C. 10:61-1.2, the Medicaid and NJ FamilyCare fee-for-service programs' Independent Clinical Laboratory Services manual and N.J.A.C. 8:44 and 8:45.

(c) All independent clinical laboratories and other entities performing clinical laboratory testing shall possess certification as required by CLIA 1988, and the New Jersey Department of Health and Senior Services rules found in N.J.A.C. 8:44 and 8:45.

(d) An ophthalmologist may claim reimbursement for clinical laboratory services performed for the practitioner's own patients within the practitioner's office, subject to the following:

1. An ophthalmologist shall meet the conditions of the CLIA regulations before he or she may perform clinical laboratory testing for Medicaid or NJ FamilyCare fee-for-service beneficiaries; and
2. The clinical laboratory tests shall be standard clinical laboratory procedures consistent with the ophthalmologist's CLIA certification, certificate of waiver or certificate of registration as an independent clinical laboratory.

(e) When the clinical laboratory test is performed on site, the venipuncture shall not be reimbursable as a separate procedure; the cost shall be included within the reimbursement for the laboratory procedure.

(f) When the ophthalmologist refers a laboratory test to an independent clinical reference laboratory:

1. The clinical reference laboratory shall be certified under the CLIA as described above at (a) and (b) to perform the required laboratory test(s);
2. The clinical laboratory shall be licensed by the New Jersey State Department of Health and Senior Services as described above at (b) and (c), or comparable agency in the state in which the laboratory is located;
3. The clinical laboratory shall be approved for participation as an independent laboratory provider by the New Jersey Medicaid or NJ FamilyCare fee-for-service program in accordance with (b) above; and
4. Independent clinical laboratories shall bill the New Jersey Medicaid or NJ FamilyCare fee-for-service program for all reference laboratory work performed on their premises. The ophthalmologist shall not be reimbursed for laboratory work performed by a reference laboratory.

10:62-1.20 Personal contribution to care requirements for NJ KidCare-Plan C and copayments for NJ KidCare-Plan D

(a) General policies regarding the collection of personal contribution to care for NJ FamilyCare-Plan C and copayments for NJ FamilyCare-Plan D services are set forth at N.J.A.C. 10:49-9.

(b) Personal contribution to care for NJ FamilyCare-Plan C services is $5.00 per visit for office

visits, except when the service is provided for preventive care.

1. An office visit is defined as a face-to-face contact with a vision care professional, which meets the documentation requirements in this subchapter and N.J.A.C. 10:62-3.

2. Office visits include eye care professional services provided in the office, patient's home, or any other site, excluding hospital, where the child may have been examined by the vision care professional. Generally, these procedure codes are set forth in N.J.A.C. 10:62-3.2 and 3.3.

(c) Vision care professionals shall not charge a personal contribution to care provided to newborns, who are covered under fee-for-service for Plan C; or for preventive services.

(d) There shall be a $5.00 copayment per visit required for vision care services for Plan D enrollees.

(e) Vision care professionals shall collect the copayment specified in (d) above except as provided in (f) below. Copayments shall not be waived.

(f) Vision care professionals shall not charge a copayment for services provided to newborns, who are covered under fee-for-service for Plan D.

10:62-1.21 Recordkeeping policies

(a) Providers shall keep such legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services. Data shall include such quantitative positive and negative findings as will be meaningful in a subsequent review. Check marks are not acceptable. The information shall be readily available to representatives of the New Jersey Medicaid and NJ FamilyCare fee-for-service programs, or its agents, as required.

(b) Records shall be kept and maintained by the provider for a period of at least five years from the date the service was rendered.

10:62-1.22 Reimbursement policies

(a) Instructions for submitting claims for payment of vision care services are provided in the Fiscal Agent Billing Supplement.

(b) Vision care services shall be identified by means of procedure codes, utilizing the Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS). The codes and maximum fee allowance schedule are listed in N.J.A.C. 10:62-3.

(c) The provider shall use the practitioner's usual and customary charge when submitting a claim for vision care services. Reimbursement for covered services furnished under the New Jersey Medicaid or NJ FamilyCare fee-for-service program shall be made on the basis of the provider's customary charge, not to exceed an allowance determined to be reasonable by the

Commissioner of the Department of Human Services, and further limited by Federal policy (42 CFR 447 Subpart B) relative to payment of practitioners and other individual providers.

1. In no event shall the charge to the New Jersey Medicaid or NJ FamilyCare fee-for-service program exceed the charge by the provider for identical services to other governmental agencies, private nonprofit agencies, trade unions or other individuals in the community.

2. If a beneficiary receives care from more than one member of a partnership or corporation in the same discipline for the same service, the maximum payment allowance shall be the same as that of a single provider. For purposes of reimbursement, optometrist and or physician, optometrist and physician groups, shared health care facility, or optometrist and physician sharing a common record shall be considered a single provider.

3. Reimbursement shall not be made for, and beneficiaries may not be asked to pay for, broken appointments.

(d) For reimbursement purposes, when the practitioner submits a claim for services, the services shall have been performed personally by the practitioner submitting the claim.

END OF SUBCHAPTER 1

SUBCHAPTER 2. OPTICAL APPLIANCES AND SERVICES

10:62-2.1 Scope

This subchapter covers the provision of optical appliances necessary for the correction of any eye vision defects.

10:62-2.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise:

"Ocularist" means a provider of artificial eyes.

"Optical appliances" mean those items, devices or appliances prescribed by a practitioner in order to aid or improve vision, or to replace the eye.

"Optician" means an individual licensed by the New Jersey State Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians, or licensed to practice as an optician in the state in which he or she performs such functions.

10:62-2.3 Providers of optical appliances and other services

(a) Within the restrictions of their respective licensure, the following are eligible providers upon fulfilling the Enrollment Process requirements in N.J.A.C. 10:49-3.2:

1. Ophthalmologists as defined in N.J.A.C. 10:62-1.2;
2. Optometrists as defined in N.J.A.C. 10:62-1.2;
3. Opticians as defined in N.J.A.C. 10:62-2.2;
4. Ocularists as defined in N.J.A.C. 10:62-2.2;
5. Independent clinics approved by the New Jersey Medicaid or NJ FamilyCare fee-for-service program to render eye care services;
6. Hospitals approved by the New Jersey Medicaid or NJ FamilyCare fee-for-service program for participation; and
7. Ophthalmologists, optometrists or opticians in another state who are duly licensed or meet the requirements of their own state with regard to the dispensing of optical appliances within that state.

10:62-2.4 Covered services

(a) The following optical appliances and services are covered under the New Jersey Medicaid and NJ FamilyCare fee-for-service programs:

1. Optical lenses (see N.J.A.C. 10:62-2.6);
2. Optical frames (see N.J.A.C. 10:62-2.7);
3. Repairs of optical appliances (prior authorization required for repairs for which the charge to the Medicaid or NJ FamilyCare fee-for-service program is $15.00 or over (see N.J.A.C. 10:62-2.5));

4. Artificial eyes (may be provided once every three years when prescribed by an ophthalmologist or an optometrist);

5. Low vision devices (prior authorization required if the total charge to the Medicaid or NJ FamilyCare fee-for-service program is $150.00 or more, see N.J.A.C. 10:62-2.5);

6. Vision training devices (prior authorization required, see N.J.A.C. 10:62-2.5);

7. Replacement of optical appliances:

i. Lenses and frames may be replaced once every two years for persons age 19 through and including 59 years of age, and once a year for persons less than 19 years or 60 years of age and older, provided there is a change of 0.50 diopter in sphere and or cylinder power, or a change of five degrees or more in cylinder axis.

ii. Lenses may be replaced more frequently than once every two years for persons 19 through and including 59 years of age or more frequently than once every year for persons less than 19 years or 60 years of age and older, providing there is a prescription change of at least 0.75 diopter in spherical and/or cylindrical power or a change in axis of eight degrees or more. Providers shall enter the previous prescription number in the Remarks section (#19) of the MC-9 claim form.

iii. When an optical appliance is destroyed in a fire or stolen, the provider shall place a written statement in the Remarks section (#19) of the MC-9 claim form and put a copy of the fire/police report in the provider's beneficiary's file.

iv. Providers may provide one replacement of frame and/or lenses per year for individuals with developmental disabilities. Provider shall place a written supporting statement and diagnosis related information in the Remarks section (#19) of the MC-9 claim form and put a copy of the developmental disabilities report in the provider's beneficiary's file.

8. Dual pairs of glasses instead of multifocal (prior authorization required, see N.J.A.C. 10:62-2.5);

9. Contact lenses (limited to replacement of contact lenses to once every two years);

10. Polycarbonated or ultraviolet filter lenses, when recommended by the prescribing practitioner as medically necessary; and

11. Intraocular lenses.

10:62-2.5 Optical appliances requiring prior authorization

(a) Form MC-9(A) (Request for Authorization and Payment--Optical Appliances) shall be used for requesting prior authorization for optical appliances. Instructions for completing the form are provided in the Fiscal Agent Billing Supplement. The completed form clearly indicating the reasons for requesting the appliance requiring prior authorization must be submitted to the Vision Care Unit, Division of Medical Assistance and Health Services, Mail Code #16, PO Box 712, Trenton, New Jersey 08625-0712. When a request for authorization is approved or denied, the provider shall receive a letter of notification from the fiscal agent.

(b) Items requiring prior authorization should not be provided to the Medicaid or NJ FamilyCare fee-for-service beneficiary until the authorization is received by the provider. (See N.J.A.C. 10:49-6).

(c) Authorization becomes invalid upon termination of eligibility for the New Jersey Medicaid or NJ KidCare fee-for-service programs, except when the termination occurs between the time the optical appliance is ordered and the time the optical appliance is dispensed. (Note: The provider shall use the date the optical appliance is ordered as the date of service when this situation occurs.)

(d) The following optical appliances require prior authorization:

1. Low vision devices when the total charge to the Medicaid or NJ FamilyCare fee-for-service program is $150.00 or more;
2. Vision training devices;
3. Repair of an optical appliance when the charge to the Medicaid or NJ FamilyCare fee-for-service program is $15.00 or more;;
4. Replacement of optical appliances;

i. In circumstances not covered in N.J.A.C. 10:62-2.4, the replacement of an optical appliance requires prior authorization. For example: If lost, broken and irreparable, or prescription change is less than 0.50 diopter or 5 degrees in axis.

5. Dual pairs of glasses instead of multifocal;
6. Optical tints (except rose, one and two, grey or brown plastic lenses 10 percent to 20 percent);
7. High index lenses;
8. Special base curve;
9. Artificial eye if provided more frequently than once every three years;
10. Intraocular lenses implantations if for more than two implantation procedures per beneficiary per lifetime; and
11. All other optical appliance items requiring additional charges or not identified in N.J.A.C. 10:62-3.4 (Procedure Codes and Maximum Fee Schedule for Vision Care Appliances).

(e) Optical appliance services rendered to Medicaid or NJ FamilyCare fee-for-service beneficiaries who are enrolled in a health maintenance organization which includes these services in its benefits package must be prior authorized by the HMO/physician case manager. See N.J.A.C. 10:49-19 and 20 for specifics on prepaid health plans which serve the Medicaid and NJ FamilyCare fee-for-service population and the Fiscal Agent Billing Supplement for details for obtaining prior authorization.

10:62-2.6 Standards and policies regarding lenses

(a) Lenses shall be first quality ophthalmic lenses meeting the requirements published by American National Standard Institute (available from the American National Standards Institute, 11 West 42 St., New York, N.Y. 10036, tel. 212-642-4900.

(b) Safety lenses shall meet impact resistant standards as set forth in the United States Food and Drug Administration regulations (21 CFR 3.84).

(c) For pricing purposes, all prescriptions shall be written in minus cylinder form.

(d) The total correction shall be at least 0.50 diopter in spherical or cylindrical power in the initial prescription for glasses.

(e) New lenses are reimbursable only if a change exists; that is, at least 0.50 diopter in spherical or cylinder power, or a change of five degrees or more in cylindrical axis.

(f) Contact lenses may be provided for:

1. Specific ocular pathological conditions (for example, Keratoconus, monocular surgical aphakia to effect binocular vision, anisometropia of 3.0 diopters or more;
2. Patients whose vision cannot be improved to at least 20/70 with regular lenses but improvement of vision can be accomplished to 20/70 or better; and
3. Replacement of a contact lens within two years is allowed only if there has been a significant change in basic lens parameters (design or prescription) prior authorization is required, see N.J.A.C. 10:62-2.5.

(g) The policy for duplication or reproduction of the same correction is as follows:

1. A re-examination and new prescription are required if more than one year (or two years in the case of an individual 19 through and including 59 years of age) has elapsed since the date of the original prescription.

(h) The New Jersey Medicaid and NJ FamilyCare fee-for-service programs will not pay for replacement of optical appliances which may have been lost, broken, damaged or stolen unless prior authorized.

(i) Prior authorization is required for individuals with significant pathological conditions requiring optical tints other than rose, one and two, grey or brown plastic lenses 10 percent to 20 percent.

(j) Polycarbonate lenses (Y5201) may be provided in special situations when maximum protection is indicated and recommended in writing by the prescribing practitioner, but not in conjunction with the ultraviolet filter lens described in (k) below.

(k) Ultraviolet filter lens (V2755) may be provided in special situations when maximum ultraviolet protection is indicated for the preservation of tissue integrity and recommended in writing by the prescribing practitioner, but not in conjunction with the polycarbonate lens described in (j) above.

(l) The following are not covered under the New Jersey Medicaid and NJ FamilyCare fee-for-service programs::

1. Gradient tint;

2. Oversize lenses;
3. Photochromatic lenses;
4. Prescription sunglasses;
5. Rimless lenses;
6. Temporary glasses; and
7. Progressive lenses.

10:62-2.7 Standards and policies regarding frames

(a) Plastic, nonflammable frames acceptable to the New Jersey Medicaid and NJ FamilyCare fee-for-service programs shall meet the following minimum criteria:

1. The manufacturer's name and the size of the frame shall be properly identifiable on the frame;
2. The temples shall be wire-reinforced;
3. A hinge rivet shall pass through the reinforcing temple wire;
4. The material shall contain no scratches, fissures or bubbles;
5. There shall be no material discoloration at the time of dispensing; and
6. The frame shall not be expanded beyond 1 millimeter of the original size when the lenses are inserted.

(b) Wire-metal frames are not covered under the New Jersey Medicaid and NJ FamilyCare fee-for-service programs.

10:62-2.8 Standards regarding guaranty/warranty

All rights, benefits, and services applicable to a private paying patient shall apply to the same extent to the Medicaid or NJ FamilyCare fee-for-service beneficiary.

10:62-2.9 Ocular prostheses

Artificial eyes and intraocular lenses, stock or custom-made, shall be of plastic material.

10:62-2.10 Approved fabricating laboratory

(a) For purposes of the New Jersey Medicaid and NJ FamilyCare fee-for-service programs, an approved fabricating laboratory shall have the necessary equipment, licensed personnel and capability to completely surface and finish new optical glass or plastic lenses or partially finished lenses.

(b) The laboratory shall be able to provide all services necessary to completely furnish eyeglasses as may be requested by an optical dispenser and is subject to approval by the New Jersey Medicaid or NJ FamilyCare fee-for-service program. A provider may call the Vision Care Unit (609-588-2729) to ascertain if a laboratory is Medicaid or NJ FamilyCare fee-for-service-approved.

10:62-2.11 Recordkeeping policies

(a) Providers shall keep such legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services, which are subject to post audit review. Such information shall be readily available to the representatives of the New Jersey Medicaid and NJ FamilyCare fee-for-service programs or its agents as required.

(b) The records as required by (a) above shall include the following:
1. Name of the beneficiary;
2. Address of the beneficiary;
3. Medicaid or NJ FamilyCare fee-for-service identification number;
4. Original prescription;
5. Date of the prescription received;
6. Date of the dispensing to the beneficiary;
7. Invoice from fabricating laboratory and material purchase invoices, as applicable; and
8. All supportive statements and reports, for example fire report, police report, developmental disabilities, medical necessity, etc.

(c) Records shall be kept and maintained by the provider for a period of at least five years from the date the service was rendered.

10:62-2.12 Reimbursement policy

(a) Instructions for submitting claims for payment of optical appliances are provided in the Fiscal Agent Billing Supplement.

(b) Optical appliances must be identified by means of procedure codes, utilizing the Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS). The codes and maximum fee allowance schedule are listed in N.J.A.C. 10:62-3.

(c) The reimbursement policy of the New Jersey Medicaid and NJ FamilyCare fee-for-service programs provides for payment to the provider of the actual invoice cost of the optical appliance plus a dispensing fee. Providers are requested to indicate the actual invoice cost of the material when submitting a claim. Actual invoice cost is defined as the net amount paid by the provider, reflecting all discounts or special purchase agreements. The service (dispensing) fee, to which the provider is entitled, should be indicated as a separate item.

(d) The maximum allowable reimbursement for frames is not to exceed an allowance determined to be reasonable by the Commissioner, Department of Human Services. However, providers shall only bill the New Jersey Medicaid or NJ FamilyCare fee-for-service program for the actual invoice cost of the frame when submitting a claim for payment. Actual invoice cost is defined as the net amount paid by the provider, reflecting all discounts or special purchase agreements. Frames are reimbursable only if they meet the criteria listed in N.J.A.C. 10:62-2.7.

(e) Optical appliances are reimbursable under the New Jersey Medicaid and NJ FamilyCare fee-for-service programs only when prescribed by a provider of professional eye services as defined in N.J.A.C. 10:62-1.3.

(f) Non-physician services and equipment/supplies furnished to hospital inpatients by outside providers shall not be billed directly to the New Jersey Medicaid or NJ FamilyCare fee-for-service program. Providers shall submit a bill/invoice to the hospital for payment.

(g) The cost of intraocular lenses is reimbursable to hospitals or ambulatory surgical centers where the surgery is performed.

(h) Reimbursement by the New Jersey Medicaid or NJ FamilyCare fee-for-service program shall be made for covered services provided to eligible beneficiaries only.

END OF SUBCHAPTER 2

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:62-3.1 Introduction

(a) The New Jersey Medicaid and NJ FamilyCare fee-for-service programs utilize the Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology (CPT) architecture, employing a five-position code and as many as two 2-position modifiers. Unlike the CPT numeric design, the (CMS) assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three-level coding system.

1. Level I Codes (Narratives found in CPT): These codes are adapted from CPT for utilization primarily by Physicians, Podiatrists, Optometrists, Certified Nurse-Midwives, Independent Clinics and Independent Laboratories. CPT is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians. Copyright restrictions make it impossible to print excerpts from CPT procedure narrative for Level I codes. Thus, in order to determine those narratives it is necessary to refer to CPT, which is incorporated herein by reference, as amended and supplemented. (The CPT is available from the Order Department of the American Medical Association, PO Box 109050, Chicago, Illinois 60610.)

2. Level II Codes (Narratives found in N.J.A.C. 10:62-3.5): These codes are assigned by CMS for physician and non-physician services which are not in CPT.

3. Level III Codes (Narratives found in N.J.A.C. 10:62-3.3 and 3.5): These codes are assigned by the Division to be used for those services not identified by CPT codes or CMS-assigned codes. Level III codes identify services unique to New Jersey.

(b) The HCPCS procedure codes listed in this subchapter are divided into two sections: HCPCS procedure codes for professional services are in N.J.A.C. 10:62-3.2; and HCPCS procedure codes for vision care appliances are in N.J.A.C. 10:62-3.5.

(c) The responsibility of the provider when rendering professional services and requesting reimbursement is listed in N.J.A.C. 10:62-1, Reimbursement Policies; for optical appliances, N.J.A.C. 10:62-2, Reimbursement Policies.

1. When filing a claim, the appropriate HCPCS procedure codes must be used in conjunction with the modifiers when applicable.

2. The use of a HCPCS procedure code will be interpreted by the New Jersey Medicaid and NJ FamilyCare fee-for-service programs as evidence that the practitioner personally furnished, at a minimum, the service which the code represents.

3. For reimbursement purposes, when reference is made to any of the following services it is understood that they were performed by the practitioner submitting the claim:

i. Office, hospital, nursing home, or residential health care facility visits; and

ii. Any and all parts of a history or eye examination.

4. Date(s) of service(s) shall be indicated on the claim form and in the practitioner's own record for each service billed.

5. When submitting a claim, the practitioner shall always use the practitioner's usual and

customary fee. The Medicaid or NJ FamilyCare fee-for-service dollar value designated for the HCPCS procedure codes represents the New Jersey Medicaid and NJ FamilyCare fee-for-service programs' maximum payment for the given procedure.

i. All references to time parameters shall mean the practitioner's time in reference to the service rendered unless it is otherwise indicated.

(d) Regarding specific elements of HCPCS procedure codes which require attention of providers, the lists of HCPCS procedure codes for vision care services are arranged in tabular form with specific information for a code identified under columns with titles such as: "IND," "HCPCS CODE," "MOD," "DESCRIPTION," AND "MAXIMUM FEE ALLOWANCE." The information identified under each column is summarized below:

Column Title	Description
Ind	(Indicator-Qualifier) Lists alphabetic symbols used to refer a provider to information concerning the New Jersey Medicaid and NJ FamilyCare fee-for-service programs' qualifications and requirements when a procedure and service code is used. Explanation of indicators and qualifiers used in this column are identified below: “L" preceding any HCPCS procedure code indicates that the complete narrative for the HCPCS procedure code is located in N.J.A.C. 10:62-3.3. "N" preceding any HCPCS procedure code indicates that qualifiers are applicable to that code. These qualifiers are listed by HCPCS procedure code in N.J.A.C. 10:62-3.4. “P" preceding any HCPCS procedure code indicates that prior authorization is required. (See N.J.A.C. 10:62-1 and 2.) "R" preceding any HCPCS procedure code indicates a HCPCS procedure code for a factor necessary in the fabrication of a lens prescription. For proper reimbursement, the code must be listed on the claim form (MC-9) in addition to the basic lens code
HCPCS Code	Lists the HCPCS procedure code for professional services and vision care appliances.
MOD	Lists alphabetic and numeric symbols. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of alphabetic and/or numeric characters at the end of the HCPCS procedure code. The New Jersey Medicaid and NJ FamilyCare fee-for-service programs' recognized modifier codes for vision care services are as follows: Modifier Code — Description YF — Optical Frame Service Fee: To be used when patient supplies

	his/her own Medicaid or NJ FamilyCare fee-for-service plastic frame.
22	Unusual Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier "22" to the usual procedure code and enclosing a copy of the invoice. When billing, a copy of the invoice is required. (See "Comprehensive Eye Examination with Diagnostic Fields" in N.J.A.C. 10:62-3.4.)
52	Reduced Services: Under certain circumstances, a service or procedure is partially reduced or eliminated at the practitioner's election. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of the modifier "52" signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic services. This also applies when using Stock Bifocals. (See "Bifocal Lenses, Glass or Plastic" in N.J.A.C. 10:62-3.5(d).) List the code narrative. (Narratives for Level I codes are found in CPT. Narratives for Level II and III codes are found in N.J.A.C. 10:62-3.2 and 3.5.)
Maximum Fee Allowance	Lists New Jersey Medicaid and NJ FamilyCare fee-for-service programs' maximum reimbursement schedule. If the symbols "B.R." (By Report) are listed instead of a dollar amount, it means that additional information will be required in order to properly evaluate the service. Attach a copy of the report to the claim form. If the symbols "N.A." (Not Applicable) are listed instead of a dollar amount, it means that the service is not reimbursable.

(e) Regarding alphabetic and numeric symbols under "IND" and "MOD", these symbols when listed under the "IND" and "MOD" columns are elements of the HCPCS coding system used as qualifiers or indicators (as in the "IND" column) and as modifiers (as in the "MOD" column). They assist the provider in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.

1. These symbols and/or letters must not be ignored because, in certain instances, requirements are created in addition to the narrative which accompanies the HCPCS procedure code as written in CPT. The provider must be careful to enter the additional requirements, and not just the HCPCS procedure code narrative. These requirements must be fulfilled in order to receive reimbursement.

2. If there is no identifying symbol listed, the HCPCS procedure code narrative prevails.

(f) For surgical codes relevant to Ophthalmologists see Physicians Services Chapter (N.J.A.C. 10:54-4, CMS Healthcare Common Procedure Coding System).

10:62-3.2 HCPCS Procedure Codes and maximum fee schedule for professional vision care services

IND	HCPCS Code	MOD	Maximum Fee Allowance
	65205		16.00
	65210		32.00
	65220		32.00
	65222		48.00
	65430		16.00
	66999		BR
	67820		16.00
	67938		30.00
	67850		42.00
	67999		BR
	68040		16.00
	68399		BR
	68761		30.00
	68801		8.00
	68840		8.00
	68899		B.R.
	76511		40.00
	76511	26	18.00
	76511	TC	22.00
	76512		60.00
	76512	26	34.20
	76512	TC	25.80
	76513		60.00
	76513	26	24.00
	76513	TC	36.00
	76516		40.00
	76516	26	18.00
	76516	TC	22.00
	76519		44.00
	76519	26	20.00
	76519	TC	24.00
	76999		B.R
N	92002		22.00
N	92004		22.00
N	92004	22	26.00
N	92012		22.00
N	92014		22.00

N	92014	22	26.00
N	92020		16.00
	92060		21.00
P N	92065		16.00
N	92081		16.00
N	92082		16.00
N	92083		16.00
N	92100		16.00
N	92120		16.00
N	92130		16.00
	92135		20.00
N	92140		16.00
	92225		25.00
	92226		21.00
	92235		53.00
	92250		10.00
N	92260		15.00
	92265		25.00
	92270		11.00
	92275		20.00
	92286		12.00
	92326		70.00
	92533		4.00
	92541		15.00
	92542		19.00
	92544		14.00
	95930		23.00
	99025		22.00
	99052		5.00
	99082		B.R.
	99199		B.R.
N	99201		23.50
N	99202		23.50
	99203		32.30
	99204		32.30
	99205		32.30
N	99211		16.00
N	99212		23.50
N	99213		23.50
N	99214		23.50
N	99215		23.50
	99241		44.00

99242	64.70
99243	64.70
99244	91.10
99245	91.10
99251	34.50
99252	64.70
99253	64.70
99254	91.10
99255	91.10
99261	16.00
99262	23.50
99263	23.50
99271	44.00
99272	64.70
99273	64.70
99274	91.10
99275	91.10
99281	16.00
99282	23.50
99283	23.50
99284	32.30
99285	32.30
99301	32.30
99302	32.30
99303	32.30
99311	23.50
99312	23.50
99313	23.50
99321	32.30
99322	32.30
99323	32.30
99341	23.50
99342	23.50
99343	51.50

10:62-3.3 Professional vision care service codes and narratives not found in CPT-4 (Level II and Level III codes)

IND	HCPCS Code	MOD	DESCRIPTION	MAXIMUM FEE ALLOWANCE

	W9200	Low Vision Exam, a continuation of a comprehensive eye exam, with limited additional tests to determine if low vision devices would benefit vision problems that cannot be normalized by conventional spectacles. NOTE: This low vision examination is used as an additional procedure at the time of the original examination.	$12.00
P	W9205	Low Vision Work-up with written report. Prior Authorization required. This is a battery of extensive tests and independent procedures to determine a device or a combination of devices that would permit an individual to enhance visual functions.	70.00
P	W9210	Vision training and written report (prior authorization required)	70.00
N	W9220	Slit lamp examination	16.00

10:62-3.4 Qualifier for professional vision care services

(a) Qualifiers for professional vision care services are summarized below:

HCPCS Code	MOD	Procedure
1. COMPREHENSIVE EYE EXAMINATION		
92002 92004 92012 92014		Comprehensive Eye Examination--Refers to a new or established patient.
2. COMPREHENSIVE EYE EXAMINATION WITH DIAGNOSTIC FIELDS		
92004 92014	22 22	Comprehensive Eye Examination with Diagnostic Fields--Refers to a new or established patient.
3. INDEPENDENT OFFICE PROCEDURES		
92020 92100 92120 92130 92140 92260		Independent Office Procedures—HCPCS 92020, 92065 92065, 92081, 92082, 92083, 92100, 92120, 92130, 92081 92140, 92260, W9205, W9210, W9220, shall not be 92082 reimbursable when performed on the same day as 92083 HCPCS 92002, 92004, 92012 or 92014.

W9205
W9210
W9220

4. OFFICE SERVICES (NEW PATIENT)

Codes 99201, 99202, 99203, 99204, 99205, 99301, 99302, 99303, 99321, 99322 and 99323 shall not be reimbursable with 92002, 92004, 92012 or 92014 on the same day.

5. OFFICE SERVICES (ESTABLISHED PATIENT)

Codes 99211, 99212, 99213, 99214, 99215, 99311, 99312 and 99313 shall not be reimbursable with 92002, 92004, 92012 or 92014 on the same day.

6. EMERGENCY DEPARTMENT SERVICES

99211
99212
99213
99214
99215

Physician's Use of Emergency Room Instead of Office:

When a physician sees his/her patient in the emergency room instead of his/her office, the physician shall use the same HCPCS for the visit that would have been used if seen in the physician's office (99211, 99212, 99213, 99214 or 99215 only).

99281
99282
99283
99284
99285

Hospital-Based Emergency Room Physicians:

When patients are seen by hospital-based emergency room physicians who are eligible to bill the Medicaid/NJ FamilyCare program, then the appropriate HCPCS is used. The "Visit" codes shall be limited to 99281, 99282, 99283, 99284 and 99285.

7. BRAIN-STEM-EVOKED RESPONSE TESTING

92280

Not reimbursable for initial testing, general screening, research studies or any situation where usefulness has not been clearly established; and therefore, it is without controversy. Code 92280--for reimbursement purposes refers to a visual brain-stem-evoked response (VBR) with interpretation. Reimbursable to hospital outpatient department as a hospital charge or to a qualified provider (office setting). The study must be personally performed by any of the following disciplines trained and experienced with VBR testing, namely Ophthalmologists, Optometrists, Neurologists, Neurosurgeons, and Psychiatrists. Criteria for testing:

i. Inconclusive test results by standard vision testing for:
   (1) Neonates and infants at risk for vision loss;
   (2) Children and adults who cannot perform behavioral testing.
ii. Suspected organic neurologic lesion within or proximal

8. UNUSUAL TRAVEL, FOR EXAMPLE, TRANSPORTATION AND ESCORT OF PATIENT

Code 99082 may be used for travel costs only associated and billed with HOUSE CALL OR HOME VISIT. (See HCPCS 99341, 99342, 99343, 99347, 99348 and 99349.)

9. HOME SERVICES

Home Visit--99343 and 99349
The Home Visit HCPCS 99343 and 99349 does not distinguish between specialist and non-specialist. These codes shall not apply to residential health care facility or nursing facility settings. These codes refer to a physician visit limited to the provision of medical care to an individual who would be too ill to go to a physician's office and/or is "home bound" due to his/her physical condition. When billing for a second or subsequent patient treated during the same visit, the visit should be billed as a home visit.
Home Visit--99341, 99342, 99344, 99345, 99347, 99348 and 99349 These HCPCS apply when the provider visits a beneficiary in the home and the visit does not meet the criteria specified under a House Call listed in N.J.A.C. 10:62-1.13.

10:62-3.5 HCPCS Procedure Codes and maximum fee schedule for vision care appliances

(a) LENS DISPENSING FEE

IND	HCPCS Code	MOD	DESCRIPTION	MAXIMUM FEE ALLOWANCE
	Y5100		Lens Service (Cataract Bifocal over + or - 10 D)	$40.00
	Y5105		Lens Service (Cataract Single Vision over + or - 10 D)	20.00
	Y5110		Lens Service (Single vision lens)	12.00
	Y5112		Lens Service (Bifocal lens)	15.00
	Y5114		Lens Service (Trifocal lens)	17.00

(b) FRAMES

	V2020		Frames, purchases	8.00
	Y5150		Frames, purchase, replacement (due to irreparable damage)	8.00
	Y9787		Repair of frames NOTE: Frame repairs charge $15.00 or more requires prior authorization	15.00
	Y5165		Frames, (dispensing fee)	8.00
	Y5165	YF	Frames, (dispensing fee) NOTE: YF--Patient supplied his or her own plastic frame	8.00

(c) SINGLE VISION LENSES, GLASS OR PLASTIC

	V2100	Sphere, single vision, plano to plus or minus 4.00, per lens	5.80
	V2101	Sphere, single vision, plus or minus 4.12 to plus or minus 7.00D, per lens	6.00
	V2102	Sphere, single vision, plus or minus 7.12 to plus or minus 20.00D, per lens	14.25
	V2103	Spherocylinder, single vision, plano to plus or minus 4.00D sphere, .12 to 2.00D cylinder, per lens	8.50
	V2104	Spherocylinder, single vision, plano to plus or minus 4.00D sphere, 2.12 to 4.00D cylinder, per lens	9.50
	V2105	Spherocylinder, single vision, plano to plus or minus 4.00D sphere, 4.25 to 6.00D cylinder, per lens	10.50
P	V2106	Spherocylinder, single vision, plano to plus or minus 4.00D sphere, over 6.00D cylinder, per lens	B.R.
	V2107	Spherocylinder, single vision, plus or minus 4.25D to plus or minus 7.00D sphere, .12 to 2.00D cylinder, per lens	10.50
	V2108	Spherocylinder, single vision, plus or minus 4.25D to plus or minus 7.00D sphere, 2.12D to 4.00D cylinder, per lens	11.50
	V2109	Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00D sphere, 4.25 to 6.00D cylinder, per lens	12.50
P	V2110	Spherocylinder, single vision, plus or minus 4.25 to 7.00D sphere, over 6.00D cylinder, per lens	B.R.
	V2111	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00D sphere, .25 to 2.25D cylinder, per lens	13.50
	V2112	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00D sphere, 2.25D to 4.00D cylinder, per lens	14.50
	V2113	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00D sphere, 4.25 to 6.00D cylinder, per lens	15.50
	V2114	Spherocylinder, single vision, sphere over plus or minus 12.00D, per lens NOTE: With any cylinder	19.50

R	V2115		Lenticular, (myodisc), per lens, single vision	25.00
R	V2116		Lenticular lens, nonaspheric, per lens, single vision	35.00
R	V2117		Lenticular, aspheric, per lens, single vision	45.00
P	V2118		Aniseikonia lens, single vision	B.R.
P	V2199		Not otherwise classified, single vision lens	B.R.

(d) BIFOCAL LENSES, GLASS OR PLASTIC
(up to and including 28mm seg width, add power up to and including + 4.00D)

	V2200		Sphere, bifocal, plano to plus or minus 4.00D per lens	12.00
	V2200	52	Sphere, bifocal, plano to plus or minus 4.00D, per lens--Stock lens	7.00
	V2201		Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00D per lens	14.25
	V2201	52	Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00D per lens--Stock lens	7.00
	V2202		Sphere, bifocal, plus or minus 7.12 to plus or minus 20.00D, per lens	18.85
	V2203		Spherocylinder, bifocal, plano to plus or minus 4.00D sphere, .12 to 2.00D cylinder, per lens	13.50
	V2204		Spherocylinder, bifocal, plano to plus or minus 4.00D sphere, 2.12 to 4.00D cylinder, per lens	14.50
	V2205		Spherocylinder, bifocal, plano to plus or minus 4.00D sphere, 4.25 to 6.00D cylinder, per lens	15.50
P	V2206		Spherocylinder, bifocal, plano to plus or minus 4.00D sphere, over 6.00D cylinder, per lens	B.R.
	V2207		Spherocylinder, bifocal plus or minus 4.25 to plus or minus 7.00D sphere, .12 to 2.00D cylinder, per lens	18.60
	V2208		Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 2.12 to 4.00D cylinder, per lens	20.65
	V2209		Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 4.25 to 6.00D cylinder, per lens	21.65

P	V2210	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00D sphere, over 6.00D cylinder, per lens	B.R.
	V2211	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00D sphere, .25 to 2.00D cylinder, per lens	23.60
	V2212	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 2.25 to 4.00D cylinder, per lens	25.60
	V2213	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 4.25D to 4.00D cylinder, per lens	25.60
	V2214	Spherocylinder, bifocal, sphere over plus or minus 12.00D, per lens NOTE: With any cylinder	25.60
R	V2215	Lenticular (myodisc), per lens, bifocal	40.00
R	V2216	Lenticular, nonaspheric, per lens, bifocal	55.00
R	V2217	Lenticular, aspheric, per lens, bifocal	65.00
P	V2218	Aniseikonia, per lens, bifocal	B.R.
P	V2219	Bifocal seg width over 28mm	B.R.
	V2220	Bifocal add over 3.25D NOTE: Per pair	15.00
P	V2299	Specialty bifocal	B.R.

(e) TRIFOCAL LENSES, GLASS OR PLASTIC
(up to and including 28mm seg width, add power up to and including 3.25D)

V2300	Sphere, trifocal, plano to plus or minus 4.00D, per lens	19.50
V2301	Sphere, trifocal, plus or minus 4.12 to plus or minus 7.00D, per lens	21.75
V2302	Sphere, trifocal, plus or minus 7.12 to plus or minus 20.00, per lens	26.35
V2303	Spherocylinder, trifocal, plano to plus or minus 4.00D sphere, .12-2.00D cylinder per lens	21.00
V2304	Spherocylinder, trifocal, plano to plus or minus 4.00D sphere, 2.25 to 4.00D cylinder, per lens	22.00
V2305	Spherocylinder, trifocal, plano to plus or minus 4.00D sphere, 4.25 to 6.00 cylinder, per lens	23.00

	V2306	Spherocylinder, trifocal, plano to plus or minus 4.00D sphere, over 6.00 cylinder, per lens	30.00
P	V2307	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00D sphere, .12 to 2.00D cylinder, per lens	B.R.
P	V2308	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 2.12 to 4.00D cylinder, per lens	B.R.
P	V2309	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 4.25 to 6.00D cylinder, per lens	B.R.
P	V2310	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00D sphere, over 6.00D cylinder, per lens	B.R.
P	V2311	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00D sphere, .25 to 2.25D cylinder, per lens	B.R.
P	V2312	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 2.25 to 4.00D cylinder, per lens	B.R.
P	V2313	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 4.25 to 6.00D cylinder, per lens	B.R.
P	V2314	Spherocylinder, trifocal, sphere over plus or minus 12.00D cylinder, per lens NOTE: With any cylinder	B.R.
P-R	V2315	Lenticular, (myodisc), per lens, trifocal	B.R.
P-R	V2316	Lenticular nonaspheric, per lens, trifocal	B.R.
P-R	V2317	Lenticular, aspheric, per lens, trifocal	B.R.
P	V2318	Aniseikonia, per lens, trifocal	B.R.
P	V2319	Trifocal seg width over 28mm	B.R.
	V2320	Trifocal add over 3.25D NOTE: Per pair	15.00
P	V2399	Specialty trifocal	B.R.

(f) VARIABLE SPHERICITY LENSES
(Welsh 4 drop, hyperaspheric, double drop, etc.)

P	V2410	Variable sphericity lens, single vision, full field, glass or plastic, per lens	B.R.
P	V2430	Variable sphericity lens, bifocal, full field,	B.R.

		glass or plastic, per lens	
P	V2499	Variable sphericity lens, other type	B.R.

(g) CONTACT LENSES

P	V2500	Contact lens, pmma, spherical, per lens	B.R.
P	V2501	Contact lens, pmma, toric or prism ballast, per lens	B.R.
P	V2502	Contact lens, pmma, bifocal, per lens	B.R.
P	V2503	Contact lens, pmma, color vision deficiency, per lens	B.R.
	V2510	Contact lens, gas permeable, spherical, per lens	120.00
P	V2511	Contact lens, gas permeable, toric, prism ballast, per lens	B.R.
P	V2512	Contact lens, gas permeable, bifocal, per lens	B.R.
	V2513	Contact lens, gas permeable, extended wear, per lens	120.00
	V2520	Contact lens hydrophilic, spherical, per lens	100.00
P	V2521	Contact lens hydrophilic, toric, or prism ballast, per lens	B.R.
P	V2522	Contact lens hydrophilic, bifocal, per lens	B.R.
	V2523	Contact lens hydrophilic, extended wear, per lens	100.00
P	V2530	Contact lens, scleral, per lens (for contact lens modification, see 92325)	B.R.
P	V2599	Contact lens, other type	B.R.

(h) LOW VISION AIDS

	V2600	Hand held low vision aids and other nonspectacle mounted aids	75.00
	V2610	Single lens spectacle mounted low vision aids	150.00
P	V2615	Telescopic and other compound lens system including distance vision telescopic, near vision telescopic and compound telescopic lens system	B.R.

(i) PROSTHETIC EYES

	V2623		Prosthetic, eye, plastic, custom	643.00
	V2624		Polishing/resurfacing of ocular prosthesis	33.00
P	V2625		Enlargement of ocular prosthesis	205.00
P	V2626		Reduction of ocular prosthesis	110.00
P	V2627		Scleral covered shell	878.00
P	V2628		Fabrication of fitting of conformer	171.00
P	V2629		Not otherwise classified, prosthetic eye	B.R.

(j) INTRAOCULAR LENSES (Reimbursed to Ambulatory Surgical Centers Only)

	V2630		Anterior chamber intraocular lens	150.00
	V2631		Iris supported intraocular lens	150.00
	V2632		Posterior chamber intraocular lens	150.00

(k) MISCELLANEOUS

	V2700		Balance lens, per lens NOTE: Single vision	5.00
	V2700	22	Balance lens, per lens NOTE: Bifocal	10.00
P	V2710		Slab off prism, glass or plastic, per lens	B.R.
	V2715		Prism, per lens	7.00
P	V2718		Press-on lens, Fresnell prism, per lens	B.R.
P	V2730		Special base curve, glass or plastic, per lens	B.R.
	V2740		Tint, plastic, rose 1 or 2, per lens NOTE: Per pair	3.50
	V2741		Tint, plastic, other than rose 1-2, per lens NOTE: Grey or Brown, 10%-20% only, per pair	3.50
	V2742		Tint, glass rose 1 or 2, per lens NOTE: Per pair	3.50
P	V2743		Tint, glass other than rose 1 or 2, per lens	B.R.
	V2755		U.V.—Lens NOTE: Per Pair	10.00
	V2770		Occluder lens, per lens	10.00
P	V2785		Processing, preserving and transporting corneal tissue (Reimbursed to Ambulatory Surgical Centers Only)	B.R.
P	V2799		Vision service, miscellaneous	B.R.

P	Y5200	Vision training devices	B.R.
	Y5201	Polycarbonate lens NOTE: Per pair	20.00

APPENDIX A
Current through July 16, 2001; 33 N.J. Reg. No. 14

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is filed as an incorporated Appendix of this chapter/manual but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Fiscal Agent Billing Supplement, write to:

Unisys
PO Box 4801
Trenton, New Jersey 08650-4801

or contact

Office of Administrative Law
Quakerbridge Plaza, Building 9
PO Box 049
Trenton, New Jersey 08625-0049